LEGISLATIVE AUDIT COMMISSION

Program Audit
Office of the Inspector General
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PROGRAM AUDIT

OFFICE OF THE INSPECTOR GENERAL
DEPARTMENT OF HUMAN SERVICES

DECEMBER 2002

Recommendations - 8

Summarized below are the recommendations contained in the program audit of the Office of the Inspector General, Department of Human Services. The program audit was conducted by the Office of the Auditor General pursuant to the Abused and Neglected Long Term Care Facility Residents Reporting Act. The Act states that the audit shall specifically include the Inspector General's effectiveness in investigating reports of alleged neglect or abuse and make recommendations for sanctions to DHS and the Department of Public Health. The Inspector General during the audit period was Odell Thompson, Jr. The current Inspector General is Sydney Roberts, and she was appointed May 19, 2003. The Inspector General is appointed by the Governor and confirmed by the Senate for a four-year term.

Background

The General Assembly established the Office of the Inspector General (OIG) in 1987. The purpose of the OIG, refined over time, is to investigate allegations of abuse or neglect reported within State-operated facilities and programs serving the mentally ill and developmentally disabled, as well as at facilities or programs licensed, certified or funded by DHS. In FY02, DHS operated 19 State facilities and licensed, certified, or funded over 400 community agencies. The 19 facilities served 13,680 individuals. The 400 community agency programs provided services to approximately 24,500 individuals with developmental disabilities and approximately 160,000 individuals with mental illness.

In FY02, a total of 1,636 allegations of abuse or neglect were reported to the OIG, 948 from State facilities and 688 from community agencies. In FY02, 46% of investigations were completed in 60 days, up from 25% in FY2000. In FY02, the OIG substantiated abuse or neglect in 253 of 1,503 closed investigations of incidents reported to the OIG. 6% of the cases in facilities were substantiated, while 31% of the cases in community agencies were substantiated. Three additional allegations were substantiated and reclassified as abuse or neglect, and 12 more cases investigated by the State Police were substantiated, bringing the FY02 total of substantiated cases to 272 among 3,489 allegations. Over the past nine fiscal years, the Inspector General has not used sanctions against facilities. The Abused and Neglected Long Term Care Facility Residents Reporting Act (210 ILCS 30/6.2) gives the Inspector General broad authority to recommend sanctions. At the close of this audit, the Inspector General was working to develop a new directive that specifies criteria when sanctions could be recommended.

Currently, the most frequently used action in a substantiated case is administrative action, which includes suspension, termination, reprimand or retraining.

As of June 30, 2002, the OIG had 68 staff. This represents an increase of nine positions overall, but investigative staff for abuse or neglect investigations have decreased from 39 to 27. Training of OIG investigators had improved in FY2000 audit, but there were again problems in the FY02 audit period. The Deputy Inspector General did not review all substantiated cases of abuse or neglect as required. The Inspector General, Deputy Inspector General, or a designee did not review 12 of 18 substantiated cases of abuse or neglect tested by the auditors.

According to Appendix A, the OIG closed 4,411 investigations on allegations, regardless of category at intake, in FY01 and 3,489 in FY02. There are 35 allegation descriptions divided into four categories: abuse, neglect, death, serious and other injuries, and other reportable incidents. Half of the allegations are described as "accidental or unknown cause" or "other physical abuse" (not including imminent danger, serious injury, sexual, verbal, or psychological abuse). The percentage of allegations substantiated was 8% in FY01 and FY02. The percentage of allegations substantiated in FY02 at the individual DHS facilities varied from 0% at Zeller to 12% at Singer. Elgin had the greatest number of substantiated allegations-13, or 5%.

Recommendations

1. Assure that clear and consistent investigative guidance, which allows investigative effectiveness to be judged over time, is available for investigators.

Findings: Various changes in investigative guidance may have left investigative staff unclear on appropriate definitions and investigative requirements. During FY02, investigators operated under three different versions of Administrative Rule 50. Additionally, memos, directives and guidelines were all in effect during the audit period.

OIG Updated Response: Implemented. The first Inspector General with command law enforcement experience and an investigative background was appointed beginning FY01. During the evaluation period of the Office of the Inspector General, between July 2000 and January 2001, it was determined that the Investigative Guidelines were very vague and without consistent investigative direction. Beginning March 2001, Investigative Guidelines began to be converted into Investigative Directives. To ensure that clear and consistent investigative guidance was followed during the conversion period the following procedure was implemented. When inconsistencies in the Guidelines were discovered a memorandum outlining the changes in the investigative procedures was issued until a new directive was established. Investigative standards are and should be based on clear and definitive operational procedures and not questionable or unclear operational procedures. This change

from Guidelines to Directives was done to ensure accountability and that investigative procedures were clear and consistent throughout all of the investigative bureaus.

2. **Assure that notification and investigation requirements in the Abused and Neglected Long Term Care Facility Residents Reporting Act are satisfied (210 ILCS 30/6.2b). Include an interagency agreement that stipulates responsibilities and revise the current administrative rules to be consistent with the Act (59 Illinois Administrative Code 50.50 h).**

Findings: Neither the OIG nor State Police are fulfilling statutory responsibilities established under the Act. The Act requires that within 24 hours of receiving a report of suspected abuse or neglect, the OIG must determine if possibly a crime was committed, and if so, notify the State Police. However, the State Police get involved if the possible perpetrator is a State employee. Otherwise, the OIG must reach out to the local jurisdiction. The most recent version of OIG's administrative rule does not require OIG to report all possible criminal acts to State Police as required by statute.

OIG Updated Response: Partially Implemented. The OIG will work with the State Police to ensure that criminal allegations are reported to the appropriate law enforcement authority. An interagency agreement between the Office of the Inspector General and the Illinois State Police was signed on January 9, 2003. Revising the Administrative Rule is currently under study.

State Police Response: ISP is working with DHS to establish an interagency agreement which stipulates responsibilities of each agency for the purpose of ensuring reporting procedures, notification protocols and investigation requirements for all matters subject to the Act. Both agencies are cooperatively developing a system to monitor cases referred to the ISP to ensure the cases are disposed of properly and timely.

3. **Continue to work to improve the timeliness in investigations of abuse and neglect.**

Findings: In FY02, 46% of investigations were completed in 60 calendar days, up from 25% in FY2000. In FY02, 41 cases took longer than 200 days to complete, down from 547 cases in FY2000. Some investigations are outside the direct control of OIG, such as cases referred to the State Police or to Clinical Services and case completion is delayed.

OIG Updated Response: Implemented. Where appropriate the ISP and other local law enforcement agencies are allowing OIG to conduct simultaneous administrative investigations. This cooperative arrangement will enable OIG to complete its administrative investigation in a more timely manner. Additionally, the development of a clinical division is under study which will eliminate the need of forwarding cases to DHS Clinical Services.

4. Work with State facilities and community agencies to ensure that allegations of abuse or neglect are reported within the time frame specified in State law and OIG administrative rules.

Findings: Alleged incidents of abuse and neglect are not being reported to the OIG by facilities and community agencies in the time frames required by administrative rule. 30% of facility incidents and 63% of community agency incidents were not reported within the one-hour time frame in the first half of FY02. In January 2002, the OIG increased the required reporting time from one hour to four hours. After this change, 16% of facility incidents were not reported timely and 50% of community agency incidents were not reported timely.

OIG Updated Response: Accepted and partially implemented. The OIG developed an electronic method for analyzing timeliness and is in the process of developing a formal approach to address agencies and facilities who consistently fail to report in a timely manner. The OIG will continue to monitor and ensure that allegations are reported timely.

5. Assure that all cases that require review by the Inspector General, Deputy Inspector General, or a designee receive that review.

Findings: The Deputy Inspector General did not review all substantiated cases of abuse or neglect as required by OIG's investigative guidance. The auditors sampled 18 substantiated cases, 12 cases were not reviewed by the Inspector General, the Deputy Inspector General, or a designee.

OIG Updated Response: Implemented. Prior to January 1, 2002, the designee for the review of substantiated cases investigated by community agencies was the Investigation Bureau Chief. This review procedure was in accordance with the OIG Guidelines in effect at that time. As a result of a statutory change that became effective January 1, 2002, all substantiated cases are to be reviewed by the Inspector General, Deputy Inspector General or a designee. This change was memorialized in an Investigative Directive issued April 17, 2002.

An Administrative Directive has been amended to accurately reflect the review and approval process of all OIG case reports.

Auditor Comment: Although the OIG indicates that the Bureau Chief was the designee, they provided no documentation of that designation. In addition, the Bureau Chief reviewed all cases and the Guidelines in effect prior to the Directive state that, "When the Bureau Chief approves a substantiated case file, he/she will submit the investigative case file to the Inspector General/designed for review and Signature." The Guideline did not differentiate between facility and community agency investigations.

6. Establish a process to accurately track and follow-up on cases for which no response to a substantiated case of abuse or neglect has been received from a State facility or community agency. If the community agency or facility fails to provide a written response, consider recommending appropriate sanctions.

Findings: The OIG has not established a process to insure that all written responses for substantiated cases from facilities and community agencies are completed and received as required by statute. The OIG did not have written responses for five substantiated cases in FY02. Additionally, the written responses for 76 substantiated cases had not been added to OIG's database.

OIG Updated Response: The OIG tracks written responses through the database records and the investigative case file. State facilities and community agencies are notified by letter of their requirement to submit a written response. A Case Closure Directive has been developed. The OIG has implemented an automated process which tracks and monitors the receipt of written responses. This automated process also identifies those written responses which are overdue. A monthly report of all overdue responses is sent to the appropriate oversight State agency. Where warranted OIG may consider recommending sanctions.

Auditor Comment: OIG's database did not adequately track all cases where there was no written response received. The database had blanks for 76 substantiated cases. OIG officials indicated that the written response had been received for all but five cases; however, the data was not entered into OIG's database.

7. Ensure that all OIG investigators meet training requirements as set forth by OIG investigative guidance.

Findings: Although training of OIG investigators had improved in the FY2000 OIG audit, for FY01 and FY02, four OIG investigators had not obtained one of the required investigation related courses, and two of the four employees did not receive courses within the first year of employment as required by OIG Guidelines. In addition, three OIG investigators had not obtained the required 10 hours of continuing education.

OIG Updated Response: Implemented. At the end of FY03, all investigators had received the required training.

8. Work with the Quality Care Board to assure that the Board meets quarterly as required by statute (210 ILCSA 30/6.3).

Findings: The Board did not meet quarterly as statutorily required. During FY01, the Board met twice, and during FY02, it met three times.

OIG Response: A member of the Inspector General's staff contacts all board members to determine their availability for the scheduled board meeting and reports that information to the chairman. The chairman of the Quality Care Board determines if a meeting will be held.